# Suicide Assessment and Intervention

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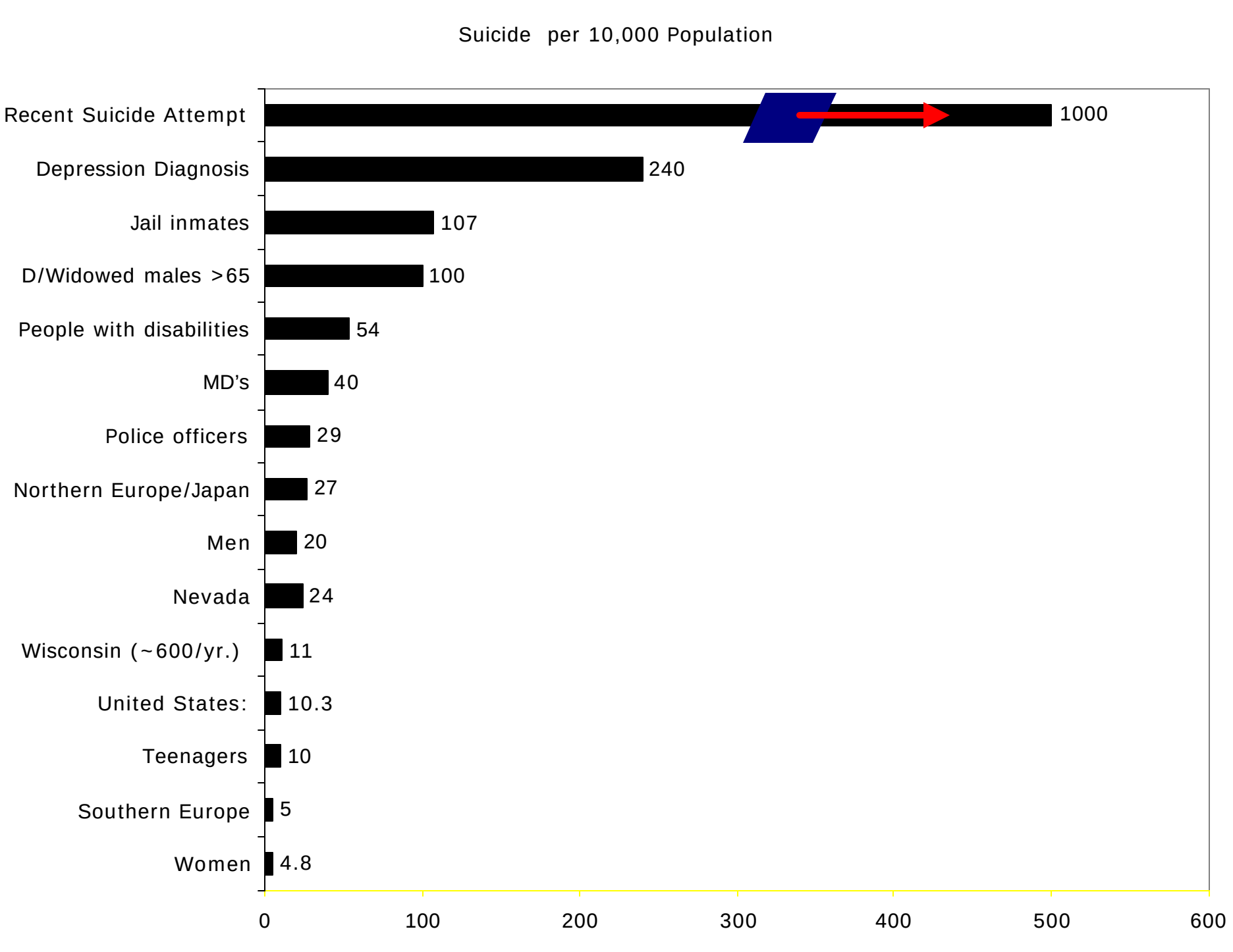
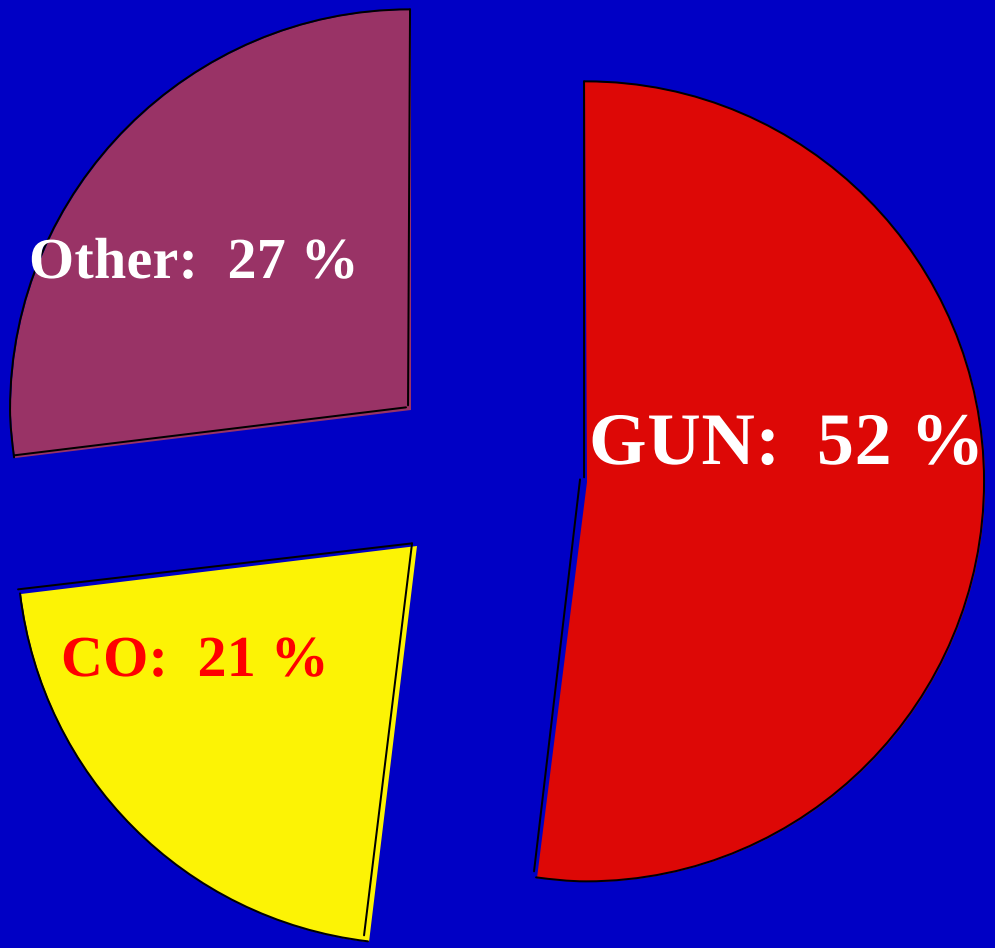
## U.S. Suicide Statistics:

- **30,000 /yr,  81 people a day**
- **8th leading cause of death**
- **More people kill themselves than are murdered**
- **15-24 year olds most likely to suicide and > 65 y.o.**


Suicide per 10,000 Population
Recent Suicide Attempt
1000
Depression Diagnosis
240
Jail inmates
107
D/Widowed males >65
100
People with disabilities
54
MD's
40
Police officers
29
Northern Europe/Japan
27
Men
20
Nevada
24
Wisconsin (~600/yr.)
11
United States:
10.3
Teenagers
10
Southern Europe
5
Women
4.8
0
100
200
300
400
500
600

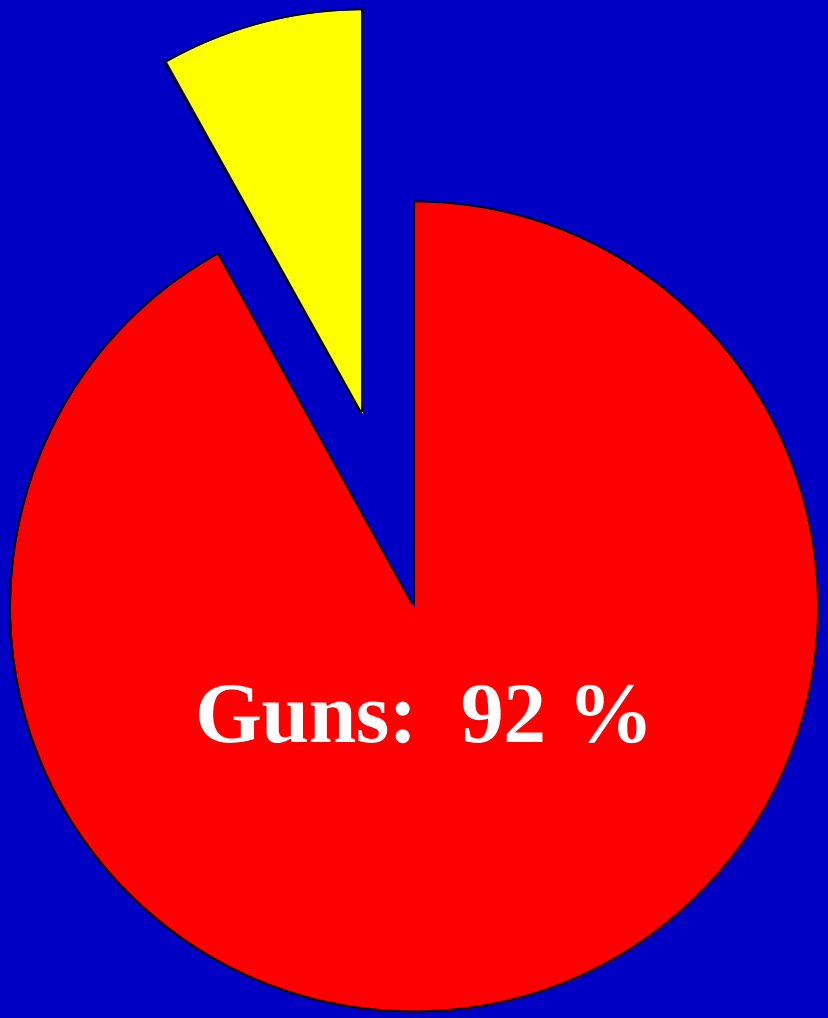
# Wisconsin statistics: How people kill themselves




**Men 5 x more likely to suicide than women**

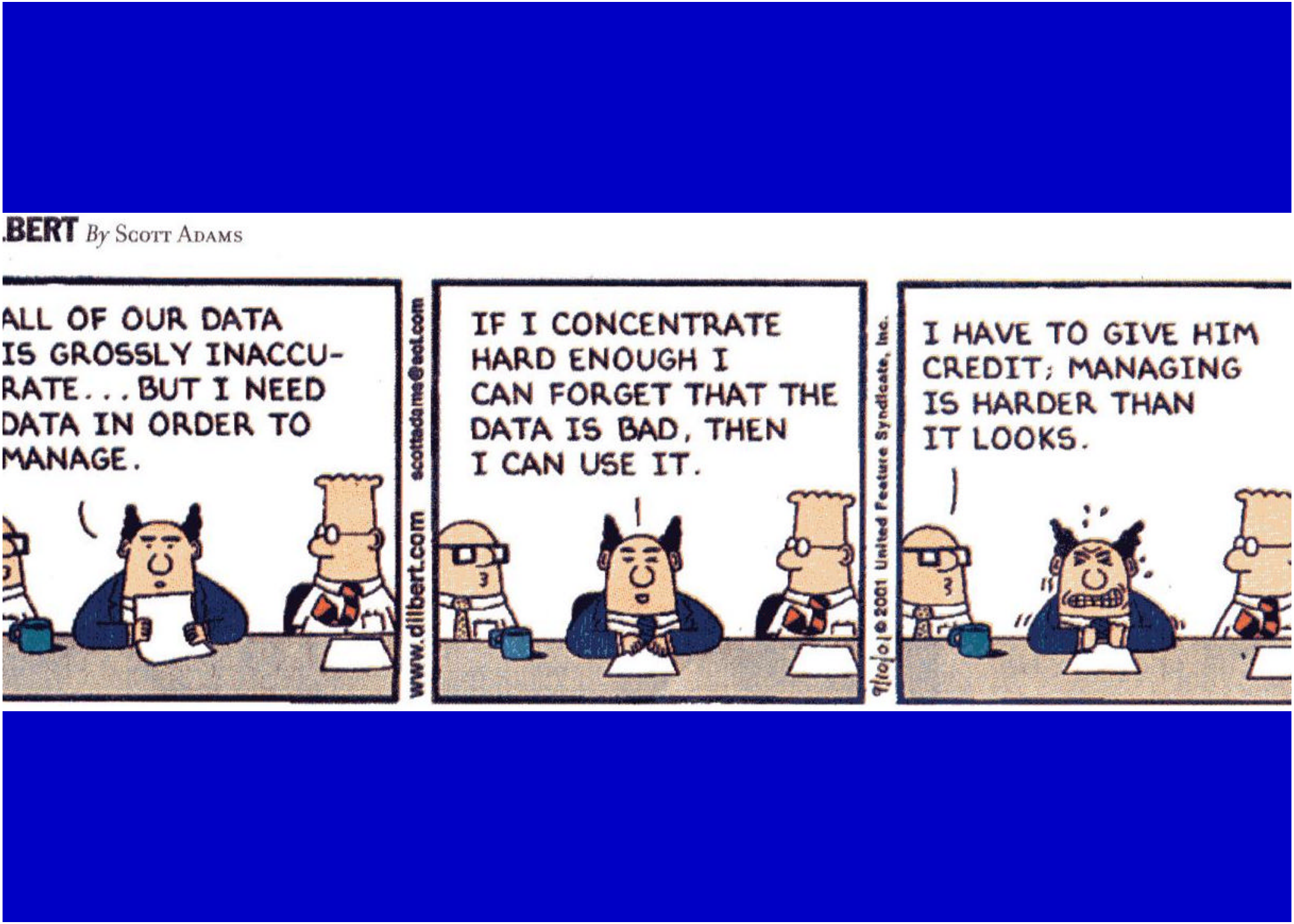
**Whites 2 x more likely than people of color**

# Wisconsin Statistics:  How Adolescents Kill Themselves:



## Problem:

- How to predict very short term risk—
- How to predict longer term risk
- What can you do to decrease both short term and long term risk


.BERT By Scott Adams
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IF I CONCENTRATE HARD ENOUGH I CAN FORGET THAT THE DATA IS BAD, THEN I CAN USE IT.
I HAVE TO GIVE HIM CREDIT; MANAGING IS HARDER THAN IT LOOKS.
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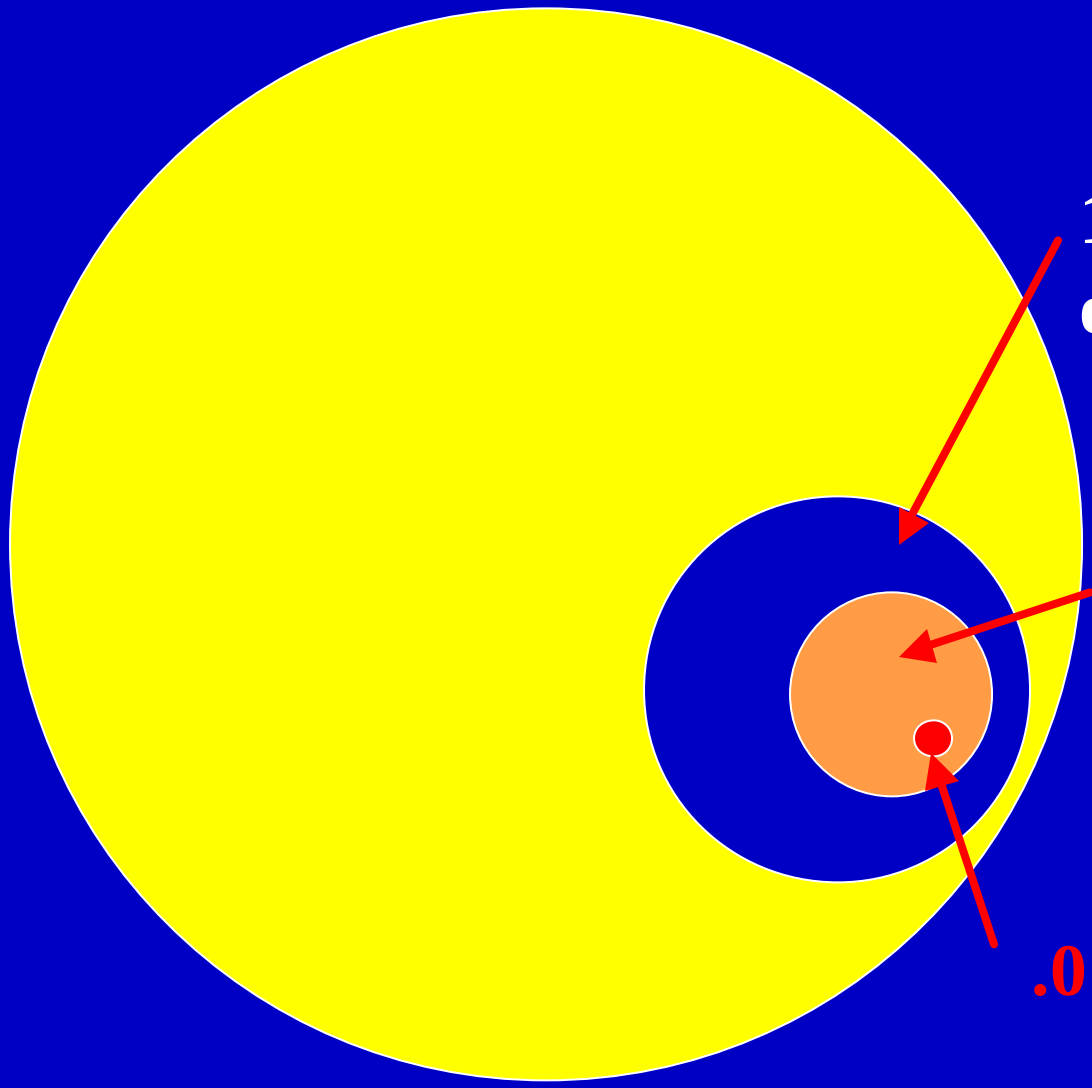
# Suicide ideation, and even suicide attempts are fairly common



14 % lifetime prevalence of suicidal ideation

4 % lifetime prevalence of suicide plan

.01 % will complete suicide

# Problem of predicting low base rate behavior

- 10 % of suicide attemptors die of suicide
- 1% die in the year after this attempt

- Ex. problem of assessing chest pain if there were no EKG or cardiac enzymes: still have data from history and clinical exam
  - mistakes of false inclusion and false exclusion are inevitable
- **ERGO: you cannot always predict, or always keep the patient safe**

## Suicide attempt:

**ANY self harm attempt from someone expressing the intent to kill themselves**

- **para-suicide (rather than suicide gesture) non-lethal suicide attempt**

**Vs**

**Self harm attempt for some other reason**

## Clinical ratings scales for suicide risk NOT useful in predicting suicide for an individual patient

- But use them to make sure that available data is considered in an organized way
- Easier to predict risk over the next 24-48 hours than later

## Ex. 1: 62 y.o. women brought in by her husband who is a very prominent businessman in town

- She recently found out he had been having an affair, and while he is for the moment still living in the house, she is not sure whether he will be moving out or what will happen now
- he came home from work and found her sprawled out in the living room very sedated
- several pill bottles were empty around her which he brought in with her to the ER
- she is tearful, upset, not sure if she wants to live or what she wants to do, but she would like to go home, perhaps to her sister whom she has not yet told what is going on
- he is very concerned about her and demands that she be hospitalized and evaluated by a psychiatrist before she is allowed to leave

## Ex. 2: 62 y.o. prominent business man brought in by 911 after his wife found him drunk in the car in the garage with the motor running

- His wife recently found out he had been having an affair—she is now staying with her sister, and he is not sure if his wife is really leaving him or not. She found him in the garage when she came home to pick up clothes.
- He does not care if he lives or dies—he acknowledges it might be easier if he were to die but says he is not suicidal
- He DOES NOT want to be admitted—DEMANDS to be let go
- Does NOT want to talk about it—feels the whole thing was stupid
- Promises he will follow up with his regular doctor and will see a psychiatrist if his regular doc feels this is really needed

## Prediction of short term risk (24-48 hr) more reliable than long term risk

- Shorter period of time
- More similar the social and psychological context

## What is there attitude about surviving

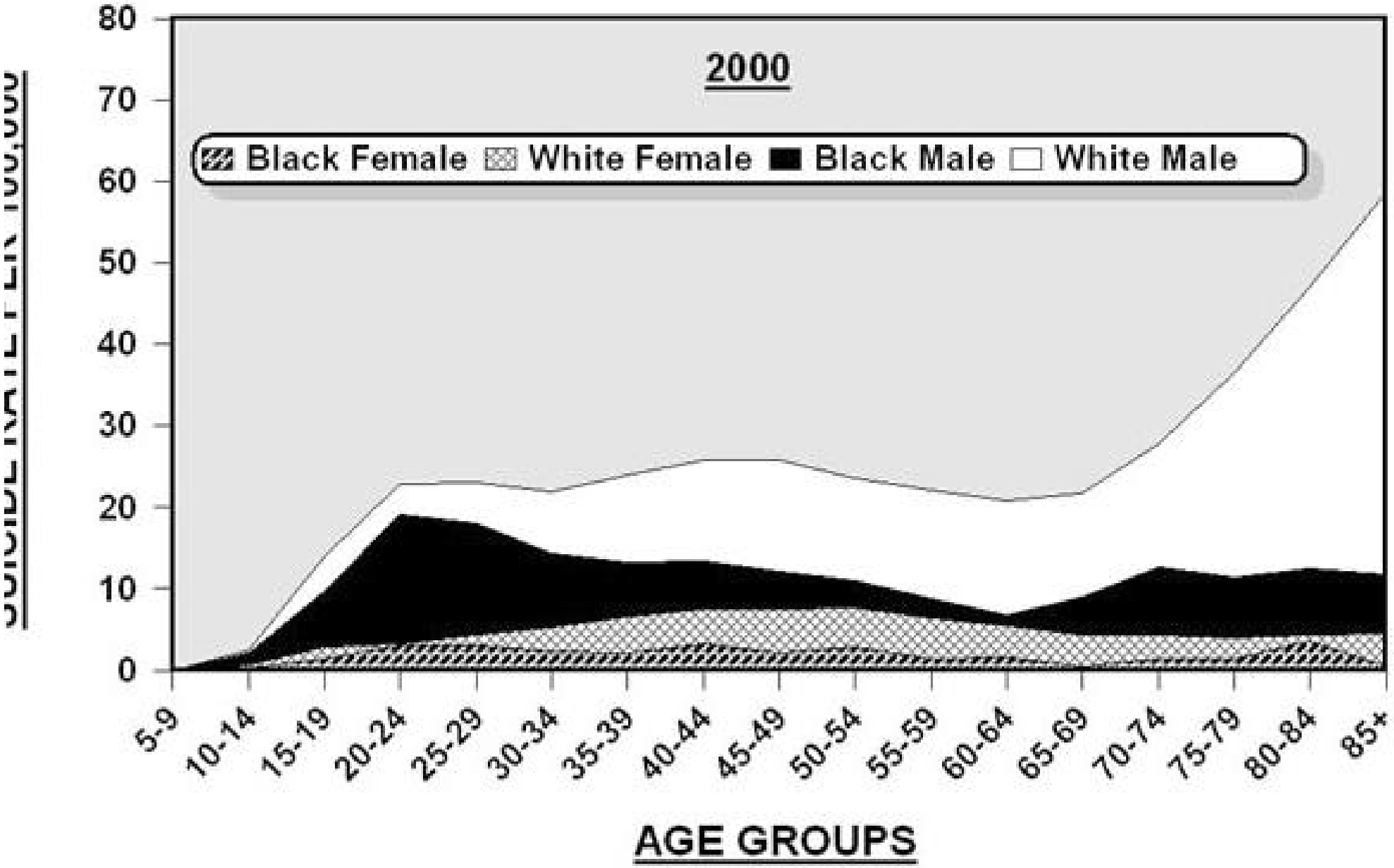
- stress diathesis model—
- best predictor is past history of suicide attempt
- risk factors do not predict suicide
- screening tools have not been found useful
  - intent to die
  - plan in mind
  - available lethal means

# 32 prospective studies of suicide

**Will inevitably admit many people where this was not needed, and will not admit some people who subsequently die either in the near future or eventually**

**Best predictor is past attempt**

- **Risk Rating Scale**
- **Can still use clinical exam**




Source: National Institute of Mental Health
Data: Centers for Disease Control And Prevention, National Center For Health Statistics


"I need a card that expresses my innermost feelings for under three bucks!"

## Be alert for the potentially suicidal patient

- Consider which patients may be depressed.
- Be alert for nonverbal feelings of hopelessness and despair.
- Ask about suicide directly.
- Feelings of wanting to hurt oneself are different from feelings of wanting to kill oneself--ask about each separately

# Many Mental Health Illness Associated with Suicide

- Depression
- Bipolar
- Schizophrenia
- Panic
- Borderline Personality Disorder
- Substance Abuse

# Suicide Assessment

- Assessment of suicidal ideation and intent
- Assessment of strengths and supports
- Assessment of statistical risk factors

4. Clinical intervention/crisis intervention

# General considerations in crisis intervention:

- Be interested in any recent change
- Be active
- Get a DETAILED story of what happened when
  - helps organize the sense of chaos
  - Provides critical information
- Listen and give the patient permission to talk
- Make sure everyone else also has a chance to tell their story

## Do not dismiss suicidal feelings with casual reassurance.

- Give the patient a chance to talk about both wanting to die and wanting to live, before helping the patient decide to live.
- Do not let patients become carried away with apologetic, remorseful or self-punitive behavior about their suicidal feelings.

# Assessment Techniques:

**Shawn Shea 1998**

- **Behavioral Incident: ask for specific behavior, details or trains of thought**
  - **When did you buy the pills?**
  - **Were you thinking of killing yourself when you bought them?**
  - **What did you do after you bought them?**
  - **When did you take them?**
  - **What happened then?**

# Assessment Techniques:

**Shawn Shea 1998**

- **Gentle Assumption: assumes the behavior is occurring**
  - **What other ways have thought about killing yourself**
  - **What other street drugs are you using?**
  - **How many jobs have you been fired from?**

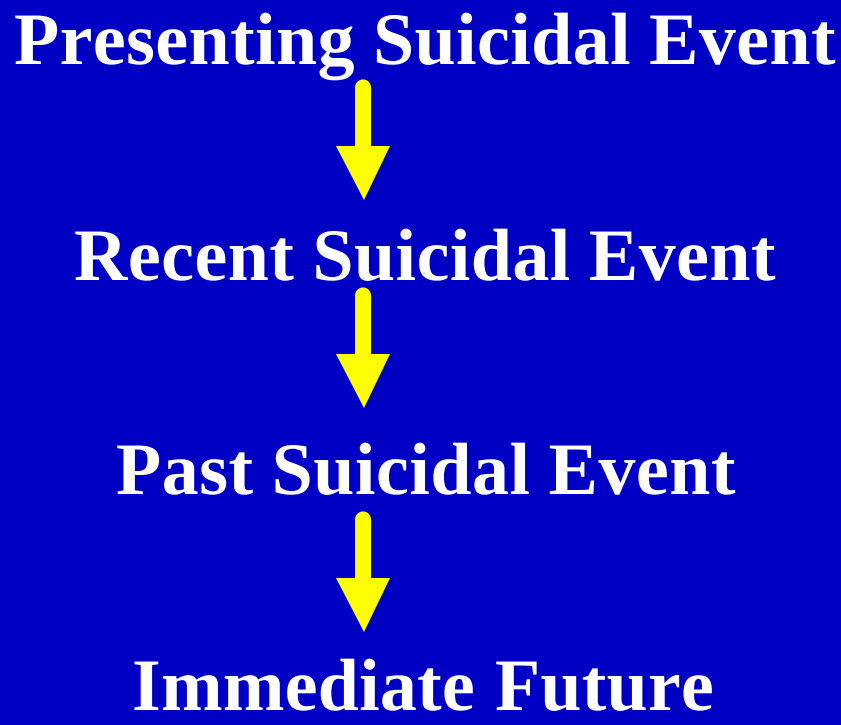
# Assessment Techniques:

**Shawn Shea 1998**

- **Denial of the Specific: gently assume a specific behavior in the question**
  - **Have you thought about shooting yourself?**
  - **Have you tried cocaine?**
  - **Have you been arrested?**
  - **Have you ever had an OWI?**

# CASE: Chronological Assessment of Suicidal Events

Shawn Shea 1998



# 1. Presenting Suicidal Event (and ideation)

**Why now? What was the final straw?**

- **Specifics of plan, what, when, how**
- **Risk-rating: lethality, discoverability**
- **Action taken**
- **Alcohol, substance use, impulsivity**
- **Degree of hopelessness**
- **What stopped patient/how were they found**
- **Attitude now of being found/alive**

Adapted from Shawn Shea 1998

## Following a suicide attempt, get a detailed description of what happened, when, in what order.

- When did the patient decide to kill him or herself? What was happening at that time?
- What happened between that decision and the actual attempt?
- Consider both the actual lethality of the attempt, as well as patient's perception of lethality.

## Suicide ideation is a behavioral event

Self-reported risk. (How long can you go on as you are?)

Ask in detail about suicide thoughts, plans and preparations.

- Note specificity, availability, and lethality
- go from general to specific.

Consider the client's perception of lethality, not just actual lethality

# Evaluate current suicidal ideation (cont)

- Ask about preparations for death --
  - suicide note, giving away of possessions, etc.
- There is a small slip between "gesture" and death.
- The more specific and detailed the plan, the more available and lethal the method, the higher the risk.

## How does suicide fit into the patients life

- Suicide commonly involves another person
  - What would the suicide mean, and to whom.
  - Consider both real and fantasized consequences.
- Is the patient's account consistent?
  - Look for gaps and ambivalence.
  - What assumptions is the patient making?

## 2. Recent Events (2 months)

- **Detailed investigation of behavioral chronology**
  - **What happened when, then what, then what**
  - **Use gentle assumption and denial of specific**
  - **Consider frequency, duration, intensity**

Adapted from Shawn Shea 1998

## 3. Past Events

- **Past attempts and periods of suicidal ideation**
  - **Most serious attempts**
  - **Most recent attempts**
  - **Number/pattern of attempts**

Adapted from Shawn Shea 1998

# History of previous suicide

- Context of previous attempts may predict context of future attempts
- A history of previous attempts increases the risk of both future attempts, and the risk of a successful suicide.
- Consider history of "sub-intentioned" suicide attempts (i.e. single person car accident, etc).
- Consider the history of other kinds of impulsive behavior.

# 4. Immediate Future Events: What's Next

- What is happening NOW
- Current intention
- Assessment of Hopelessness
- Supports/strengths
  - Role of "safety contracts"
    - » Limitations
    - » Use of contracts as assessment, part of relationship

Adapted from Shawn Shea 1998

## Assess current suicide risk

- Ongoing suicide risk--consider all suicide risk factors
  - What is happening now to exacerbate riskh factors.
  - How emergent is the problem?
  - Involve spouse or family in the assessment.
- Consider the patients strengths. How has the patient managed to cope in the past.
- Help structure an overwhelming mass into a discrete set of issues.
- Consider the probability of a suicide attempt as well as probability of successful suicide.

# Sad Person scale (Patterson et al. 1983)

- Sex
- Age
- Depression

- Previous Attempt
- Ethanol abuse
- Rational thought loss
- Social Support Lacking
- Organized Plan
- No spouse
- Sickness

## Assess for psychiatric illness: Depression

- Discuss natural history and typically good course
  - generally favorable response to treatment.
  - Offer realistic hope.
- Provide a temporal context. Patient has not always been depressed and will feel better in the future.
- Consider suicide risk even after patient has begun to recover.

## Assess for psychiatric illness: Anxiety Disorder

- **Panic: (especially when co-morbid with depression**
- **Severe character disorders: Chronic crises, chaotic lifestyles that continues for years, always on the brink of suicide.**
- **Long term suicide risk is very high, even if the lethality of each individual attempt may be low**
- **Suicide risk very difficult to determine, and intervening too actively may further the escalation.**

- **Schizophrenia: Lifetime suicide risk is high, and may be very unpredictable.**

## Assess for psychiatric illness:
## Character Disorder

- Chronic crises, chaotic lifestyles that continues for years, always on the brink of suicide.
- Long term suicide risk is very high, even if the lethality of each individual attempt may be low
- Suicide risk very difficult to determine, and intervening too actively may further the escalation.

*"I try to keep my coffee buzz going till the Martini buzz kicks in."*

# Alcohol and Drug Abuse

## Cage Questions:

- Have you ever felt the need to **C**ut down on drinking?
- Have you ever felt **A**nnoyed by criticisms of drinking?
- Have you ever had **G**uilty feelings about drinking?
- Have you ever taken a morning **E**ye opener?

# Assess for psychiatric illness: Schizophrenia

- **Lifetime suicide risk is high, and may be very unpredictable.**

## Develop a treatment plan

- Separate what needs to be done
  - “right now
  - soon,
  - long term resolution of the problem.

- In the crisis situation concentrate on what needs to be done now.

# Treatment plan should include:

**A treatment plan should include:**

- **A specific appointment or follow-up appointment.**
- **A specific way for the patient to seek emergency help**
- **A support system (family, friends) willing to engage the patient.**

## Consider What other people should be involved

- Always with the patient's knowledge, and usually with patient's consent.

  may be a critical source of information as well as part of the treatment plan.

  – Assess whether involvement of a current or previous therapist would be feasible and/or useful.

  – Avoid "pseudo-confidentiality."

- Evaluate whether the patient willing to accept such help?

## Do not let the issue of suicide drop without resolution.

- Consider what needs to be done to ensure safety?
- Insist on removal of all firearms and potentially lethal medications.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BUT I'M FEELING TERRIFIC BECAUSE I'M TAKING MOOD-ALTERING PRESCRIP-TION DRUGS!
2/6/03 © 2003 United Feature Syndicate, Inc.
I CAN SEE BY YOUR EXPRESSIONS THAT MY DOCTOR IS MUCH BETTER THAN YOURS!
HOO-WAH!

# Non-Pharmacological Treatments of Depression

- **Exercise**
- **Cognitive/behavioral therapy (Mind over Mood)**
- **Interpersonal Therapy**

# Evaluation of Suicide Risk: Demographic Factors

## 1. History of previous attempts:

- 20-60% of successful suicides have tried before;
- Those who have made previous attempts are more likely to succeed;
- Second attempts commonly come within three months of first attempt.

## Evaluation of Suicide Risk: Demographic Factors

### 2. Occupational status:

- Unemployed and unskilled have higher rate than employed;
- Higher rates occur in policemen, musicians, dentists, insurance agents, physicians, and lawyers;
- Financial problems

## Evaluation of Suicide Risk: Demographic Factors

### 3. Marital status (support system):

- Single (never married) persons at greatest risk, followed by persons widowed, separated and divorced (for men)
- People "all alone in the world", people who have lost a loved one in last 6-12 months increase risk.
- No young children in the home increases risk

## Evaluation of Suicide Risk: Demographic Factors

### 4. Gender:

- Women attempt suicide three TIMES as often as men;
- Men succeed in suicide three times as often as women.

# Evaluation of Suicide Risk: Demographic Factors

## 5. Age:

- Frequency increases sharply with age in men especially in 70 and 80s
- Frequency increases slightly with age in women until sixth decade;
- Peak frequency in men is 75, in women 55.

# Evaluation of Suicide Risk: Demographic Factors

## 6. Family history:

- Suicide more common if immediate family member or other significant person attempted or committed suicide;
- Death or loss of one or both parents early in life also increases risk.

## Evaluation of Suicide Risk: Demographic Factors

### 7. Emotional factors:

- Co-morbid Mental: helplessness and hopelessness especially significant;
- Severe insomnia even without depression;
- Psychosis, particularly with "command hallucinations" or with terror, or shortly after initial improvement;
- Alcoholism and other drug-dependency (also problem of "state dependent" suicidality;
- For women, postpartum months and pre-menstrual week are period of high risk.
- Recent humiliation

# Evaluation of Suicide Risk: Demographic Factors

## 8. Health factors:

- Recent surgery or severe illness;
- Intractable pain;
- Terminal illness, all increase risk.

# Evaluation of Suicide Risk: Demographic Factors

## 9. Race/religion:

- In U.S., risk is higher among whites than african Americans, except African American men 20-35 have rate two times that of white men;
- Traditionally suicide lowest among Jews and Catholics, higher among Protestants.

# Evaluation of Suicide Risk: Demographic Factors

10. **Access to firearms:**

**References:**


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**www.mentalhealth.org/sucideprevention**